Acute pancreatitis is usually a sterile inflammatory process mostly associated with alcoholism, trauma, metabolic abnormalities, and biliary or gastrointestinal diseases. About one-third of cases remain idiopathic [2, 3]. It is generally accepted that parasites (Ascaris lumbricoides and Opisthorchis sinensis) and viral agents, including mumps virus, Coxsackie B viruses, Epstein-Barr virus, and herpes simplex virus, can cause acute pancreatitis [2, 3]. Bacterial pathogens, such as Campylobacter fetus, Mycobacterium tuberculosis, T. pallidum, Leptospira species, L. pneumophila, Salmonella species, and Y. enterocolitica, have previously been reported to cause acute pancreatitis [2, 3]. Q fever, a zoonosis due to the obligate intracellular bacterium C. burnetii, may be acute or chronic. Acute Q fever presents generally as a self-limited acute febrile illness associated with atypical pneumonia or hepatitis [4, 5]. Both the shepherdess and her husband were probably infected during the delivery of the kid by inhalation of contaminated aerosols generated from the heavily infected placenta (the major mechanism whereby Q fever is transmitted to humans) [6]. Whether her husband presented with a clinical picture suggestive of acute Q fever, the shepherdess had “query” acute pancreatitis.

To our knowledge, this is the first case report indicating that acute Q fever may present as acute pancreatitis. C. burnetii should be added to the list of microorganisms capable of inducing acute pancreatitis since Q fever requires specific antibiotic treatment. Moreover, systematic screening for Q fever may explain some of the idiopathic cases of acute pancreatitis.

Prolonged Fever Caused by Parvovirus B19–Induced Meningitis: Case Report and Review

Parvovirus B19 is a DNA virus that causes erythema infectiosum, transient aplastic crisis in patients with hemolytic anemia, arthropathy, chronic anemia in immunosuppressed patients, and fetal hydrops [1]. Meningitis due to parvovirus B19 is a rare entity, and to our knowledge, only five cases have been reported in the literature since 1990 [2–6]. Although arthritis due to parvovirus B19 has been reported, meningitis has not been reported as a cause of fever of unknown origin [7]. We describe a case of aseptic meningitis caused by parvovirus B19 in an immunocompetent patient with prolonged fever.

A previously healthy 17-year-old female was admitted to the hospital with fever (temperature, 39.6°C), myalgia, headache, nausea, and vomiting. Physical examination revealed normal mentation, neck stiffness, and several pink macules on the trunk. Laboratory studies disclosed the following: erythrocyte sedimentation rate, 25 mm/h; C-reactive protein level, <3.4 mg/dL; and negative PPD reaction. The WBC count was 5,800/μL with a normal differential cell count. Biochemical and hematologic parameters were normal. MRI of the head revealed no focal abnormalities.

References

Cardiac Cirrhosis with Cellulitis Caused by *Burkholderia cepacia* Bacteremia

*Burkholderia cepacia* is a phytopathogen that causes onion bulb rot in plants and foot rot in humans. It has emerged as an opportunistic pathogen in immunocompromised patients, particularly individuals with chronic granulomatous disease [1] and cystic fibrosis [2]. *B. cepacia* has been implicated in nosocomial outbreaks via contaminated fluid [3, 4]. Community-acquired bacteremia due to *B. cepacia* has been reported, but none of the cases were associated with cellulitis. We report a case of cardiac cirrhosis with cellulitis due to *B. cepacia* bacteremia.

A 49-year-old man presented with a 2-day history of left thigh erythematous swelling. He had no history of chronic hepatitis or cigarette smoking. He had a 13-year history of chronic lower extremity edema caused by valvular heart disease. Echocardiography showed severe tricuspid valve regurgitation and mild mitral valve regurgitation. Abdominal sonography demonstrated an uneven liver surface and hepatosplenomegaly with prominent dilatation of both the inferior vena cava and intrahepatic veins. Cardiac cirrhosis was diagnosed with a waxing and waning course of lower extremity edema.

### References


### Table 1. Clinical and laboratory characteristics of patients with meningitis due to parvovirus B19.

<table>
<thead>
<tr>
<th>Case no. [reference]</th>
<th>Age/sex</th>
<th>Underlying disease</th>
<th>Typical rash</th>
<th>Duration of fever (d)</th>
<th>WBC count (×10⁹/mm³) in CSF (differential cell count)</th>
<th>CSF protein level</th>
<th>CSF glucose level (blood level)</th>
<th>IgM to parvovirus B19</th>
<th>IgG to parvovirus B19</th>
<th>Parvovirus B19 DNA in CSF</th>
<th>Parvovirus B19 DNA in serum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 [2]</td>
<td>7 y/F</td>
<td>None</td>
<td>Present</td>
<td>7</td>
<td>339 (91% lymphocytes)</td>
<td>High</td>
<td>66 mg/dL (98 mg/dL)</td>
<td>+</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2 [3]</td>
<td>7 y/M</td>
<td>None</td>
<td>Present</td>
<td>A few days</td>
<td>112 (39% lymphocytes)</td>
<td>High</td>
<td>3.3 mmol/L (NA)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>3 [4]</td>
<td>35 y/M</td>
<td>None</td>
<td>Absent</td>
<td>NA</td>
<td>3 (2 lymphocytes)</td>
<td>High</td>
<td>4.3 mmol/L (NA)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>4 [5]</td>
<td>20 d/F</td>
<td>None</td>
<td>Absent</td>
<td>NA</td>
<td>861 (57% lymphocytes)</td>
<td>High</td>
<td>2.7 mmol/L (NA)</td>
<td>+</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>5 [6]</td>
<td>26 y/M</td>
<td>Sickle cell anemia</td>
<td>Absent</td>
<td>6*</td>
<td>10 (90% lymphocytes)</td>
<td>High</td>
<td>4.71 mmol/L (NA)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>6 [PR]</td>
<td>17 y/F</td>
<td>None</td>
<td>Absent</td>
<td>30</td>
<td>253 (95% lymphocytes)</td>
<td>High</td>
<td>43 mg/dL (105 mg/dL)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

NOTE. NA = not available; PR = present report; + = positive; – = negative.

* Patient died on day 6.